## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              | (X2) MULTIPLE CONSTRUCTION  A. BUILDING <b>01, 04</b> |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|--------------------|---|---|-------------------------------|----------------------------|
| 155766   |  | 155766  | B. WING            | B. WING   |   | R<br>10/30/2013               |                            |
| NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR CHRISTIAN HOME INC |  |   | •                  | 643   | EET ADDRESS, CITY, STATE, ZIP CODE<br>W UTICA ST<br>LERSBURG, IN 47172  | ,                             |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| {K 000}  | INITIAL COMMENTS   |   | {K 0               | 00}   |   |                               |                            |
|  | Code Recertification a conducted on 08/16/1 Indiana State Departr accordance with 42 C Survey Date: 10/30/2 Facility Number: 000 Provider Number: 15 AIM Number: 10026 Surveyor: Mark Bugr Specialist  At this PSR survey, Minc. was found in comfor Participation in Me Subpart 483.70(a), Li 2000 edition of the Na Association (NFPA) 1 | 5FR 483.70(a).<br>13<br>563<br>55766<br>7610  |                    |   |   |                               |                            |
|  | surveyed with Chapte Occupancies.  This one story facility   | er 19, Existing Health Care with a basement was   |                    |   |   |                               |                            |
|  | and fully sprinkled. T<br>system with smoke do<br>including in the baser<br>spaces open to the co<br>operated smoke dete   | ment, in the corridors, in orridors, and battery ctors in all resident sleeping as a capacity of 57 and had |                    |   |   |                               |                            |
|  | were sprinkled and al  | ents have customary access<br>I areas providing facility  |                    |   |   |                               |                            |
| LABORATORY   | DIRECTOR'S OR PROVIDER/S   | SUPPLIER REPRESENTATIVE'S SIGNATUR  | lE.                |   | TITLE   |                               | (X6) DATE                  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ' '                |                                     | IPLE CONSTRUCTION<br>NG <b>01, 04</b>   |       | (X3) DATE SURVEY  COMPLETED |  |
|--|---|--|--------------------|-------------------------------------|---|-------|-----------------------------|--|
|  |   | 155766   | B. WING            |                                     |   |       | ⋜<br>30/2013                |  |
| NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR CHRISTIAN HOME INC |   |  | '                  | 64                                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>43 W UTICA ST<br>ELLERSBURG, IN 47172 | 1 10. | 00/2010                     |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                          |  | ID<br>PREFI<br>TAG | EFIX (EACH CORRECTIVE ACTION SHOULD |   |       | (X5)<br>COMPLETION<br>DATE  |  |
| {K 000}  | Continued From page 1 services were sprinkled.  |  | {K C               | 000}                                |   |       |                             |  |
| {K 000}  |   | obert Booher, Life Safety<br>cal Surveyor on 10/31/13.   | {K 0               | 000}                                |   |       |                             |  |
|  | Code Recertification a  |  |                    |                                     |   |       |                             |  |
|  | Survey Date: 10/30/13   |  |                    |                                     |   |       |                             |  |
|  | Facility Number: 000<br>Provider Number: 15<br>AIM Number: 100267<br>Surveyor: Mark Bugr<br>Specialist  | 5766<br>7610   |                    |                                     |   |       |                             |  |
|  | Inc. was found in comfor Participation in Me<br>Subpart 483.70(a), Li<br>2000 edition of the Na<br>Association (NFPA) 1<br>and 410 IAC 16.2. Th | d with Chapter 18, New   |                    |                                     |   |       |                             |  |
|  | basement was detern<br>construction and fully<br>a fire alarm system w<br>levels including in the<br>in spaces open to the                      | the one story facility with a nined to be of Type V (111) sprinklered. The facility has ith smoke detection on all basement, in the corridors, corridors, and battery ctors in all resident rooms. |                    |                                     |   |       |                             |  |

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|--|--|---|--------------------|-----------------------------------|--|----------------------------|----------------------------|
|  |  | 155766  | B. WING            |                                   |  |                            | R<br>30/2013               |
| NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR CHRISTIAN HOME INC |  |   |                    | STREE                             | T ADDRESS, CITY, STATE, ZIP CODE UTICA ST ERSBURG, IN 47172  | 1 10/-                     | 30/2013                    |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |   | ID<br>PREFI<br>TAG |                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                            | (X5)<br>COMPLETION<br>DATE |
| {K 000}  |  | acity of 57 and had a me of this visit. ents have customary access I areas providing facility | {K C               | 000}                              |  |                            |                            |